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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 8 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11372

Registration District No. 417 — Primary Registration District No. 3024 — Registrar's No. 48

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town WEBB CITY (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 305 N. BALL. (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether In this community ____ years, months or days) 1 00

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jasper
(c) City or town Webb City (If outside city or town limits, write "RURAL")
(d) Street No. 305 N. Ball St (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Mrs. Mollie Rice (RICE)
3. (b) If veteran, name war ____
3. (c) Social Security No. ____
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Albert Rice
6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased May (Month) 8 (Day) 1874 (Year)

8. AGE: Years 65 | Months 10 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Osceola (City, town, or county) Missouri (State or foreign country)
10. Usual occupation At Home
11. Industry or business ____
MOTHER FATHER
12. Name Dresson Pennington
13. Birthplace ____ (City, town, or county) Miss. (State or foreign country)
14. Maiden name Martha Fincher
15. Birthplace ____ (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Albert Rice
(b) Address Webb City, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 30 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Castleville Cem
18. (a) Signature of funeral director Webb City Undg Co
(b) Address Webb City Mo
19. (a) MCH 29 40 (Date received local registrar) (b) J. L. Critchett M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 28th year 1940 hour 9 minute 40 A. M.
21. I hereby certify that I attended the deceased from 3-3-38 to Mar 28 1940 that I last saw h[er] alive on Mar 4 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic Myocarditis	
Due to: 1120 11-8	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	PHYSICIAN
Of autopsy	Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 377 (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature C. E. Greson (M. D. or other) Do
Address Webb City, Mo Date signed 3/28/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 440-928
Date Filed APR 4 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Myself, Registered Apprentice No. ....., working under my personal supervision.

Signed Clayton M. Johnston

Licensed Embalmer No. 3,922.

P. O. Address Webb City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

. No. 2B
—2-21-40
I X72659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11372

Registration District No. 417 Primary Registration District No. 3021 Registrar's No. 48

1. PLACE OF DEATH:
(a) County Jasper
(b) City or town Webb City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Mrs Mollie Rice
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased May - 8 - 1874 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
66	10	20	hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER / FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) MAY 4 40 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 28
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work (e) Means of injury
23. Signature C F Gregory (M. D. or other)
Address Webb City Mo Date signed

SUPPLEMENTARY

11372 (1960)